Action Plan for Suicide Prevention in Southeast Kansas

Prepared for the Kansas Department of Health and Environment Injury Prevention Program
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The Kansas Department of Health and Environment Southeast District Office provided meeting space and supplies for the Nebraska Suicide Prevention Symposium.

The following experts volunteered their time for the Expert Q&A session:

John Reeder, suicide survivor, Collyer, Kansas
Ken Loos, MS, LMLP, LCP, Community Prevention, Education and Outreach Consultant, High Plains Mental Health Center
Karen Schueler, Manager, Consultation and Education Department, High Plains Mental Health Center

The following volunteers served as small-group notetakers:

John Fulwider, facilitation consultant, Lincoln, Nebraska
Karry Moore, Public Health Educator, Kansas Department of Health and Environment Office of Health Promotion
Ismaila Ramon, Epidemiologist, Kansas Department of Health and Environment Office of Health Promotion
Jane Stueve, Adolescent and School Health Consultant, Kansas Department of Health and Environment Bureau of Family Health

Executive Summary

In Kansas, suicide was the second leading cause of injury death for ages 15-34, and the third-leading cause of injury death for all age groups combined in 2004.

To address the problem of suicide in Kansas, the Kansas Department of Health and Environment's Injury Prevention Program sponsored the Kansas Suicide Prevention Symposium. The Symposium, held July 26, 2007, in Chanute, Kansas, brought together a variety of interested stakeholders to develop this Action Plan for Suicide Prevention in Southeast Kansas. There had been suicide prevention activities conducted in the past. A volunteer workgroup, the Suicide Prevention Workgroup, had developed a broad-based Suicide Prevention Plan as a vision for suicide prevention. But the workgroup's efforts had been limited by a lack of funds and competing demands on its members. With the Symposium, Injury Prevention Program staff hoped to translate the workgroup's vision into action.

Toward this end, Injury Prevention Program staff felt the need to engage a diverse group to translate that vision into an action plan. Knowing that granting agencies look for stakeholder buy-in when making funding decisions, the Injury Prevention Program staff decided building widespread stakeholder consensus at the Symposium would position Kansas well to obtain the funds necessary to reduce injuries and death from suicide in our state.

The Injury Prevention Program staff wanted a highly efficient process that would gather input from a large group of stakeholders who all had many other activities competing for their time. Members selected a participatory process called a consensus conference to structure the Symposium. The process takes a diverse group of stakeholders with varying amounts of knowledge about a topic and puts them on a level playing field so they can reach consensus on a decision that needs to be made. Symposium participants read carefully prepared briefing materials ahead of time, listened to presentations from a mental-health expert and a suicide survivor,[1] then broke into small groups to discuss what they still needed to know to make informed choices among the options for suicide prevention initiatives. They drafted questions for an invited panel of experts, came back together in a large group to get them answered by the expert panel, then broke up again into small groups to draft action plan recommendations. Gathering once more in a large group, they voted on which three of eight recommendations should be pursued. Finally, they deliberated over how to combine recommendations receiving similar amounts of support in the initial balloting, reached a mutual understanding of what the recommendations would involve, and decided to combine aspects of several recommendations into action plan items.

Participants selected these action plan priorities:

1. Local communities and schools, by 2010, should incorporate best practices of mental health education into the health curriculum. The health curriculum should include a suicide prevention component, which would begin in the primary grades. It should have the following items:

- Coping skills

[1] A suicide survivor is a family member or friend of a person who commits suicide.

- Self-respect and respect for others
- Dealing with peer pressure
- Finances and family relationship skills
- Interpersonal relationships among teens, especially romantic issues
- How to be assertive and persistent in problem-solving (don't give up until you've resolved the problem)
- Education to reduce the stigma of mental illness

This initiative should be supplemented with mentoring/peer education and volunteer programs, all of which should be required. Efforts should be made to take advantage of federal initiatives already underway.

2. We need to eliminate the stigma of mental illness among adults not reached by the stigma-reduction efforts in elementary and secondary education. Pharmaceutical companies should be encouraged to fund public-service advertisements in various media (e.g., television, MySpace) featuring high-profile people who succeeded despite suffering mental illness.

3. We need to provide complete, accessible and affordable preventive care for people with mental illness. This includes:

- Pre- and post-crisis intervention
- Medication
- Case-management and care provider visits
- Support services (including, but not limited to, job placement and peer support)
- Housing
- Jail diversion programs
- Follow-up care

By providing these services we will prevent the escalation of their condition to the point of needing long-term hospitalization.

Introduction

In Kansas, suicide was the second leading cause of injury death for ages 15-34, and the third-leading cause of injury death for all age groups combined in 2004.

The Kansas Department of Health and Environment's Injury Prevention Program, which is partially funded by a grant from the Centers for Disease Prevention and Control, is charged with conducting an injury prevention symposium each budget year. Injury Prevention Program staff decided the focus of the 2007 symposium should be suicide prevention.

The Symposium, held July 26, 2007, in Chanute, Kansas, brought together a variety of interested stakeholders to develop this Action Plan for Suicide Prevention in Southeast Kansas. There had been suicide prevention activities conducted in the past. A volunteer workgroup, the Suicide Prevention Workgroup, had developed a broad-based Suicide Prevention Plan as a vision for suicide prevention. But the workgroup's efforts had been limited by a lack of funds and competing demands on its members. With the Symposium, Injury Prevention Program staff hoped to translate the workgroup's vision into action. Toward this end, Injury Prevention Program staff felt the need to engage a diverse group to translate that vision into an action plan. Knowing that granting agencies look for stakeholder buy-in when making funding decisions, the Injury Prevention Program staff decided building widespread stakeholder consensus at the Symposium would position Kansas well to obtain the funds necessary to reduce injuries and death from suicide in our state.

The Injury Prevention Program staff wanted a highly efficient process that would gather input from a large group of stakeholders who all had many other activities competing for their time. Members selected a participatory process called a consensus conference to structure the Symposium. The process takes a diverse group of stakeholders with varying amounts of knowledge about a topic and puts them on a level playing field so they can reach consensus on a decision that needs to be made. Symposium participants read carefully prepared briefing materials ahead of time, listened to presentations from a mental-health expert and a suicide survivor, then broke into small groups to discuss what they still needed to know to make informed choices among the options for suicide prevention initiatives. They drafted questions for an invited panel of experts, came back together in a large group to get them answered by the expert panel, then broke up again into small groups to draft action plan recommendations. Gathering once more in a large group, they voted on which three of eight recommendations should be pursued. Finally, they deliberated over how to combine recommendations receiving similar amounts of support in the initial balloting, reached a mutual understanding of what the recommendations would involve, and decided to combine aspects of several recommendations into action plan items.

This report details each step of the consensus conference to show how participants arrived at their action plan recommendations, then presents the recommendations themselves.

The Symposium

The Symposium's consensus conference process started with e-mail recruitment of a list of about 250 stakeholders selected by Injury Prevention Program staff. Staff members compiled a diverse list of stakeholders including suicide survivors, school administrators and counselors, state agency personnel, and people involved in the fields of health insurance, minority health, emergency medical services, behavioral health, and others. Thirty people responded to one of several e-mail solicitations by registering online for the Symposium. Sixteen people attended the Symposium; see Table 1 for more information about them.

Table 1: Demographics of Symposium Participants, N=16

Gender		**Education ***	
Male	5	High School	1
Female	11	College Graduate	7
		Graduate School	7
Age *		**Groups Represented**	
18-24	1	Nonprofit Organization	3
25-34	1	Health Care Facility	5
35-44	6	Public School	2
45-54	3	State or County Agency	6
55-64	3		
65+	1		

* Figures do not add to 16 because one participant did not fill out an evaluation form.

Briefing Materials

Injury Prevention Program staff compiled information about suicide for inclusion in a packet of briefing materials. Well-organized background information is important in a consensus conference because it allows participants to start from a common base of information. This can help reduce the imbalances that occur in group decision-making when some group members have access to better information than the others. The Symposium briefing materials included statistics on suicide in Kansas drawn from the Centers for Disease Control and Prevention's Injury Statistics Query and Reporting System, 14 promising prevention practices taken from the Suicide Prevention Resource Center's list of evidence-based practices, other promising practices compiled by state government agencies, and an explanation of how consensus conferences work. The briefing materials are reprinted in Appendix A.

Background Presentations

Participants heard two presentations, one from a Kansas Department of Health and Environment epidemiologist and one from the father of a teenager who died from suicide. The epidemiologist, Ismaila Ramon, reviewed statistics about suicide in Kansas.

John Reeder told a moving personal story about the death by suicide of his teenage son, Shawn, and described his volunteer efforts speaking to school students and other groups about the tragedy.

"Shawn was a very, very normal child," Reeder said, "… just a very well-liked child." Shawn was active in music and athletics and just 10 days before his suicide played the lead in his high-school musical.

Reeder had first-hand experience with emergency mental-health care because he was able to talk Shawn out of committing suicide the first time Shawn said he wanted to kill himself. Unfortunately, despite receiving inpatient and outpatient care and medication, Shawn committed suicide several months later during a phone call with his girlfriend, with whom he had been having relationship problems. Reeder said four young men out of a graduating class of 32 in his hometown had attempted suicide recently, all over relationship issues.

"Our kids grow up so fast," Reeder said. "We go from playing with toys to playing adult games." Young people have sex earlier, he said, and don't know how to deal with problems that crop up in their relationships.

First Small-Group Discussion: Draft Questions

Organizers randomly assigned participants to one of four small groups when they arrived at the Symposium. Each small group had four or five participants and a note taker who kept a record of the group's deliberations. Three Kansas Department of Health and Environment employees, plus the Symposium facilitator, served as note takers.

Small-group participants were told to discuss the briefing materials and background presentations, then draft two questions per group they still would like answered in order to make fully informed decisions about what action plan items to recommend. The groups engaged in wide-ranging and very different discussions that reflected the diversity of their members.

The first group discussed effective methods for preventing people with suicidal thoughts from acting on them; how mental health service providers address suicidal thoughts and/or actions in their patient screening procedures. The group also talked about the programs currently available in schools to address teen suicide, especially in the event a student takes his or her life. Members also talked about another age group, the elderly, wondering how one can differentiate between signs of depression, and possible accompanying suicidal thoughts, and the normal process of aging that results in sleeping problems, loss of appetite, and decreased energy levels.

Members of the second group discussed how people at high risk for committing suicide could be identified and, once identified, what treatment options are available for them. They also wanted to know whether peer pressure, family relationships, societal influence, family background, or some other factors were the main issues therapists and counselors normally came across in treating those at risk for suicide.

The third group focused on suicide survivor John Reeder's presentation, in which he noted that four young men out of a graduating class of 32 had attempted suicide in one year. Given that the four men all were dealing with relationship issues, the group wondered what could be done in both inpatient and outpatient treatment settings to address such problems. More generally, the

group also asked which mental-health services were available, and which were lacking, in southeast Kansas.

Members of the fourth group were concerned with the operation of crisis hotlines; they discussed whether people hesitate to call government-run hotlines because the operators might call the police, and whether consumer-run hotlines might be seen as more trustworthy. The group also talked about the possibility of mandating suicide prevention education in school curricula, starting early in the primary grades and extending to college.

Expert Panel Q&A

Three volunteers comprised the expert panel: John Reeder, suicide survivor, Collyer, Kansas; Ken Loos, Community Prevention, Education and Outreach Consultant High Plains Mental Health Center; and Karen Schueler, Manager, Consultation and Education Department, High Plains Mental Health Center.

Second Small-Group Discussion: Draft Recommendations

The small groups met once more, this time tasked with drafting two recommendations each for what items should be included in the Action Plan for Suicide Prevention in Southeast Kansas. The items they drafted were:

1. Provide a means by which all the disparate groups involved in suicide prevention across Kansas can band together to get the resources and support they need, perhaps by creating an umbrella group for suicide prevention organizations or creating a special arm of the mental health division of state government or the governor's mental health coalition.
2. A suicide prevention plan is needed in the schools. Coping skills introduced into the schools as part of the community. Need to teach children respect for themselves and everyone else, maybe a class in life skills that includes dealing with peer pressure, finance and family relationship skills, and how to handle a situation and be persistent. Need to teach problem-solving skills so they can develop skills to get out of a well of depression and suicidal tendencies.
3. Conduct a needs assessment, develop screening tools and identify resources.
4. Encourage local communities and schools, by 2010, to incorporate best practices of mental health education into the health curriculum, thus providing a firm basis for a holistic approach to health. This initiative should be supplemented with mentoring/peer education and volunteer programs, all of which should be required.
5. We need better wrap-around services to provide complete and preventive care for people with mental illness. This includes medication, visits, support services and follow up care. By providing these services we will prevent the escalation of their condition to the point of needing hospitalization, and perhaps reduce the number of incarcerations.
6. Develop a strategic plan, evaluation plan and outcome dissemination plan. Develop a working committee to advocate for the goal.
7. Provide training for volunteers regarding what to do in situations where a person is screened by a mental health center and does not qualify for treatment. Standardize

training within the mental health system so everyone on staff has the same understanding level.

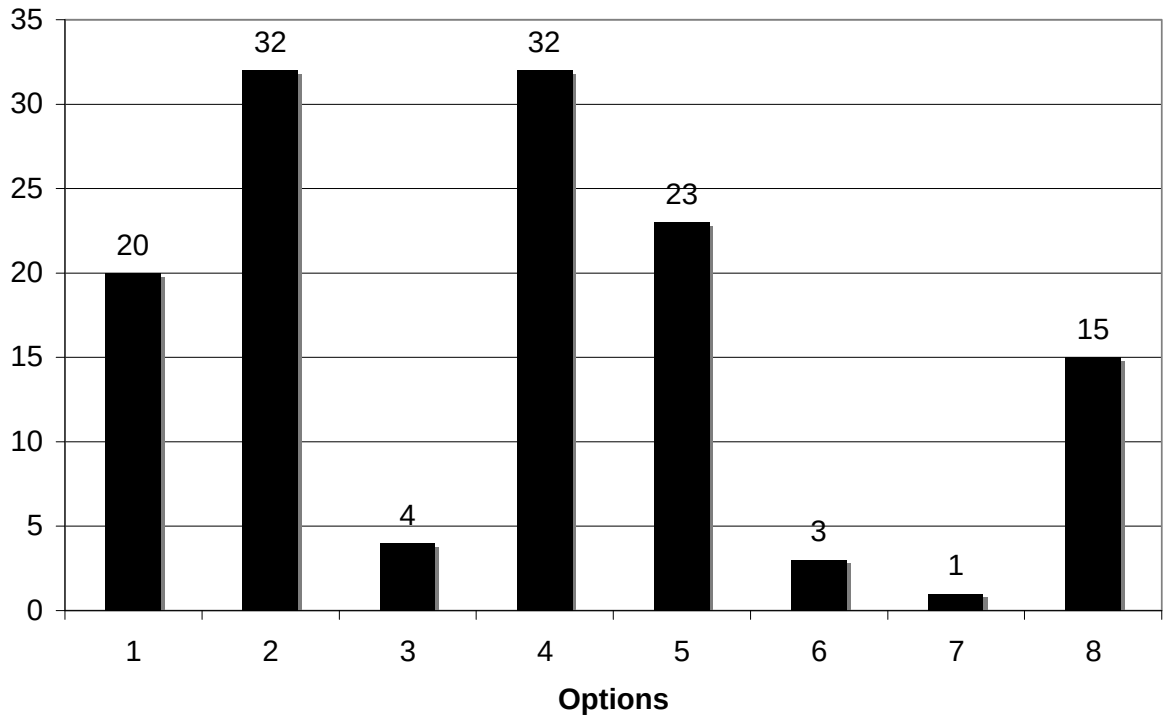
8. Education to reduce the stigma of mental illness needs to start as part of the curriculum in schools as early as 4th Grade and continue through adulthood. In school programs the focus should be dealing with relationship problems. In the case of adults a prime medium will be television; pharmaceutical companies should be encouraged to fund public-service advertisements featuring celebrities who succeeded despite suffering mental illness.

Large-Group Discussion

Participants took a break after their second small-group discussion. During the break the Symposium facilitator assembled a ballot composed of each small group's recommendations, which the group note takers had typed on laptop computers. The eight items were listed in random order on the ballot.

After the break participants each selected their top four preferences. The facilitator tabulated the votes and displayed for participants a bar chart showing which action items had the greatest support. In calculating support for the action items, the facilitator assigned four points each time an item was someone's Number One pick, three points when it was someone's second choice, two points for a third choice, and one point for a fourth choice. The results, shown in Figure 1, revealed clear group support for items two and four, both dealing with suicide prevention education in schools; item five, concerning wrap-around mental health services; and item one, concerning providing support for suicide-prevention organizations.

Figure 1: Suicide Prevention Action Plan Options



Symposium participants decided they wanted to offer just three recommendations, so the Symposium facilitator moderated a discussion of which of the several items receiving similar support should be selected.

The first suggestion was to combine items two and four, as they both dealt with school-based suicide prevention education; the group quickly agreed to this idea. Next came a discussion of the potential drawbacks of item eight; various participants thought there would that pursuing funding from pharmaceutical companies for public-service advertisements about the stigma of mental illness would present political challenges, and that it might be too difficult a task to take on at the state level. Further, some participants thought advertisements funded by pharmaceutical companies might be biased toward the companies' products, such as depression medications. Another participant noted that the federal Substance Abuse and Mental Health Services Administration already had some stigma-reducing projects underway. The group decided to offer a stigma-reduction item as its second recommendation; the intent was to address mainly an adult population who had not received education about mental health in primary and secondary school. (The group's assumption was that mental-health education in school, the focus of its first recommendation, would serve to reduce the stigma of mental illness among school students.)

The discussion on the third recommendation, about providing complete, accessible and affordable care for people with mental illness, was wide-ranging. The group initially used the term "wraparound care" to describe what it had in mind, but decided to omit that phrase because

it is jargon and some people might not understand it. The discussion included talk of adequate staffing, the sometimes-insufficient number of inpatient beds (especially in rural areas), and the need to provide complete care for people once they are released from hospitals so they do not have to be readmitted.

The discussion ended with an interactive editing session where the facilitator edited the recommendations on a large screen as participants made suggestions for wording changes and item combinations. The facilitator finally asked for any last comments, questions or objections and, seeing none, closed the discussion.

Writing the Action Plan

After writing a first draft of this report in the days following the Symposium, the facilitator e-mailed the draft to Symposium participants and gave them time to comment on it by e-mail or telephone. Comments were received from ## participants, and are reflected in this report.

Action Plan for Suicide Prevention in Southeast Kansas

Symposium participants selected three items for inclusion in the Action Plan for Suicide Prevention in Southeast Kansas. They are:

1. Local communities and schools, by 2010, should incorporate best practices of mental health education into the health curriculum. The health curriculum should include a suicide prevention component, which would begin in the primary grades. It should have the following items:

- Coping skills
- Self-respect and respect for others
- Dealing with peer pressure
- Finances and family relationship skills
- Interpersonal relationships among teens, especially romantic issues
- How to be assertive and persistent in problem-solving (don't give up until you've resolved the problem)
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This initiative should be supplemented with mentoring/peer education and volunteer programs, all of which should be required. Efforts should be made to take advantage of federal initiatives already underway.

2. We need to eliminate the stigma of mental illness among adults not reached by the stigma-reduction efforts in elementary and secondary education. Pharmaceutical companies should be encouraged to fund public-service advertisements in various media (e.g., television, MySpace) featuring high-profile people who succeeded despite suffering mental illness.

3. We need to provide complete, accessible and affordable preventive care for people with mental illness. This includes:

- Pre- and post-crisis intervention
- Medication
- Case-management and care provider visits
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- Housing
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- Follow-up care

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Appendix A: Briefing Materials

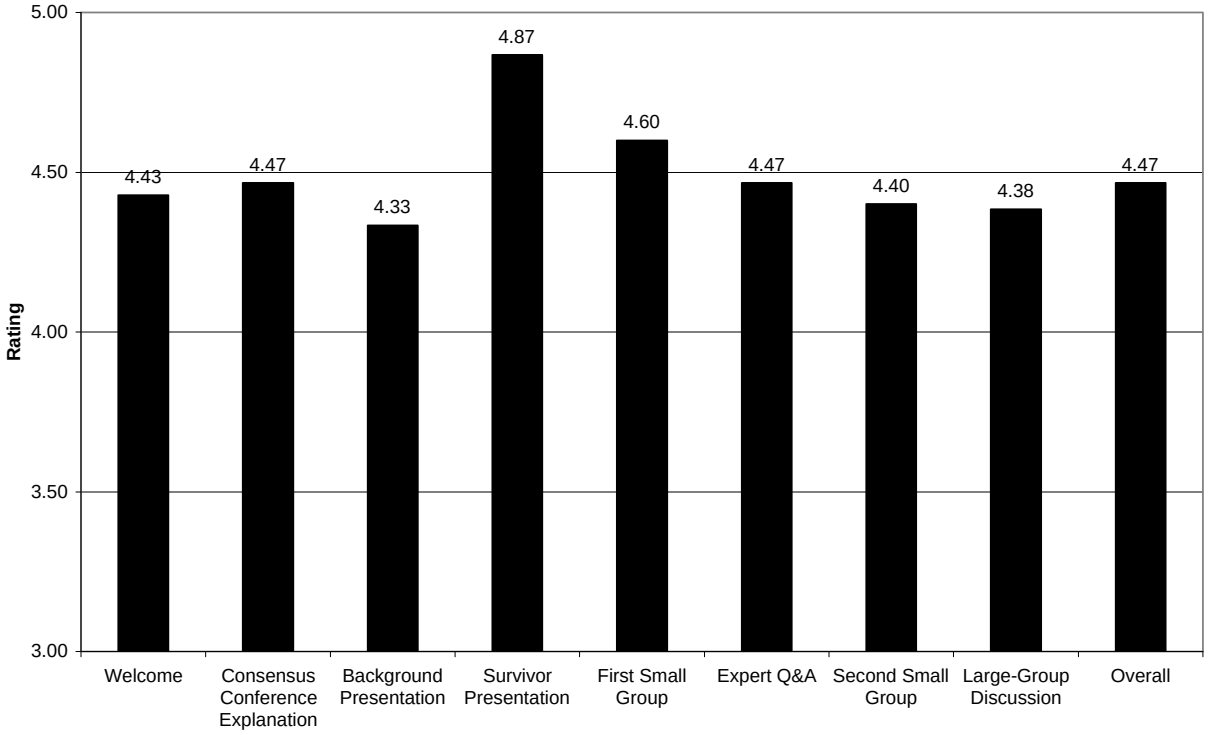
To be inserted in final version.

Appendix B: Evaluation of the Kansas Suicide Prevention Symposium

Participants completed evaluation forms at the end of the Symposium. Results from the 15 completed surveys show participants were satisfied with the experience. They gave the overall Symposium an average rating of 4.47 on a 5-point scale, and gave an average response of "better" to the question, "How would you rate the Suicide Symposium's consensus conference approach, compared with other approaches to generating recommendations from a large working group?" Asked to select the approach they would use if they were responsible for generating recommendations from a large working group, five participants, or 33%, selected consensus conference.

Below are figures showing responses to some of the evaluation questions.

Figure 2: Participant Satisfaction with Symposium



Responses are on a 5-point scale, where 5 is "very satisfied" and 1 is "very dissatisfied."

Figure 3: Consensus Conference Compared with Other Processes